XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
MARA FAUST
Deputy Attorney General
State Bar No. 111729
California Department of Justice
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7544
Facsimile: (916) 327-2247
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against, **RICHARD SAMUEL FIGHTLIN, M.D.** **422 N Kanai Dr.** **Porterville, CA 93257-6911** **Physician's and Surgeon's Certificate No. G 20598** Respondent.	Case No. 800-2015-018328 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about November 16, 2017, Complainant Kimberly Kirchmeyer, in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs, filed Accusation No. 800-2015-018328 against Richard Samuel Fightlin, M.D. (Respondent) before the Medical Board of California.

2. On or about June 28, 1971, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. G 20598 to Respondent. The Physician's and Surgeon's Certificate No. G 20598 expired on April 30, 2017, and has not been renewed.

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3. On or about November 16, 2017, Jody Wright, an employee of the Complainant Agency, served by Certified and First Class Mail a copy of the Accusation No. 800-2015-018328, Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record with the Board, which was and is 422 N Kanai Dr., Porterville, CA 93257-6911. A true and correct copy of the Accusation and related documents is attached as Exhibit A in the separate accompanying "Default Decision Evidence Packet".

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c). On or about November 27, 2017, a Niki Howley signed the green certified mail card. A true and correct copy of the signed green certified mail card is attached as Exhibit B in the separate accompanying "Default Decision Evidence Packet".

5. On or about December 27, 2017, Complainant Kimberly Kirchmeyer, in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs, filed First Amended Accusation No. 800-2015-018328 against Richard Samuel Fightlin, M.D. (Respondent) before the Medical Board of California.

6. On or about November 16, 2017, Jody Wright, an employee of the Complainant Agency, served by Certified and First Class Mail a copy of the First Amended Accusation No. 800-2015-018328, Supplemental Statement to Respondent, and Request for Discovery to Respondent's address of record with the Board, which was and is 422 N Kanai Dr., Porterville, CA 93257-6911. A true and correct copy of the First Amended Accusation and related documents is attached as Exhibit C in the separate accompanying "Default Decision Evidence Packet".

7. Service of the First Amended Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c). On or about January 6, 2018, a Niki Howley signed the green certified mail card. A true and correct copy of the signed green certified mail card is attached as Exhibit D in the separate accompanying "Default Decision Evidence Packet".

8. On or about February 5, 2018, Complainant Kimberly Kirchmeyer, in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs, filed Second Amended Accusation No. 800-2015-018328 against Richard Samuel Fightlin, M.D. (Respondent) before the Medical Board of California.

9. On or about February 5, 2018, Jody Wright, an employee of the Complainant Agency, served by Certified and First Class Mail a copy of the Second Amended Accusation No. 800-2015-018328, Supplemental Statement to Respondent, and Request for Discovery to Respondent's address of record with the Board, which was and is 422 N Kanai Dr., Porterville, CA 93257-6911. A true and correct copy of the Second Amended Accusation and related documents is attached as Exhibit E in the separate accompanying "Default Decision Evidence Packet".

10. Service of the Second Amended Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c). On or about February 12, 2018, a Niki Howley signed the green certified mail card. A true and correct copy of the signed green certified mail card is attached as Exhibit F in the separate accompanying "Default Decision Evidence Packet".

11. On or about February 20, 2018, Deputy Attorney General Mara Faust, in her capacity as the legal representative of Complainant Medical Board signed a Courtesy Notice of Default and directed her secretary, Lauren Sossaman, on February 21, 2018 to serve that Courtesy Notice of Default with attached Accusation No. 800-2015-018328, Statement to Respondent, Notice of Defense, First Amended Accusation and Second Amended Accusation to Respondent's address of record with the Board, which was and is 422 N Kanai Dr., Porterville, CA 93257-6911. A true and correct copy of the Courtesy Notice of Default and related documents is attached as Exhibit G in the separate accompanying "Default Decision Evidence Packet".

12. To date, Respondent has not filed a Notice of defense with the California Department of Justice.

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13. Business and Professions Code section 118 states, in pertinent part:

"(b) The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the license on any such ground."

14. Government Code section 11506 states, in pertinent part:

"(c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing."

Respondent failed to file a Notice of Defense within 15 days after service upon him of the Accusation, and therefore waived his right to a hearing on the merits of Accusation No. 800-2015-018328.

15. California Government Code section 11520 states, in pertinent part:

"(a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent."

16. Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing and, based on Respondent's express admissions by way of default and the evidence before it, contained in Exhibits A, B and C of the separate accompanying "Default Decision Evidence Packet", finds that the allegations in Accusation No. 800-2015-018328 are true.

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17. California Business and Professions Code section 2234 provides in pertinent part that the board shall take action against any licensee who is charged with unprofessional conduct which includes, but is not limited to, gross negligence and /or repeated negligent acts.

18 California Business and Professions Code Section 2236 of the Code states in pertinent part that the Medical Board of California shall have the power to discipline a licensee for unprofessional conduct when the licensee is convicted of any offense substantially related to the qualifications, functions, or duties of a physician and surgeon. The Code further states that a plea or verdict of guilty or a conviction after a plea of nolo contendere is deemed to be a conviction and that record of conviction shall be conclusive evidence of the fact that the conviction occurred."

19. California Business and Profession Code Section 2266 of the Code states that the failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

20. Respondent's license is subject to action under Business and Professions Code sections 2234 (b)(c), 2236 and 2266 by reasons of the following:

a. On or about October 25, 2015, Investigator Robert Glaspie of the Division of Investigation was assigned to investigate Respondent regarding his suspension of privileges from Sierra View Hospital in Porterville, California. As part of his investigation, Investigator Glaspie sent medical records and Respondent's interview to Board expert Paul Lee, M.D., who then wrote his opinion of what violations from the standard of care Respondent had committed with respect to his care and treatment of Patients D through G. as follows:

1. Dr. Lee opined that Respondent committed gross negligence during his care and treatment of Patient D by failing to evaluate and document the potential injury from this complicated operation of the ureteroscopy.

2. This expert further opined that Respondent committed gross negligence during his care and treatment of Patient E by failing to receive a complete informed consent from Patient E as well as his failure to perform adequate shockwave lithotripsey treatment.

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3. Dr. Lee found that Respondent committed three acts of gross negligence during his care and treatment of Patient F by making an incorrect pre-operative diagnosis, by Respondent regarding the presence of a right stent; by making the wrong antibiotic choice for a pre-existent infection before surgery, as well as a lack of consideration of delaying surgery in light of the infection; and Respondent's action of performing a forceful dilation of the right ureteral stricture using a semi rigid ureteroscope without a guide wire in combination with laser lithotripsy which caused ureteral injury.

4. Lastly, Dr. Lee opined that Respondent committed gross negligence during his care and treatment of Patient G by opting to perform elective surgery in a healthy, thirty-six-week pregnant woman rather than wait a few weeks until delivery of the patient's baby; Respondent failed to have a pre-operative urine test performed and documented before engaging in an invasive urological surgery; and Respondent showed a lack of concern regarding possible left ureteral injury to Patient G during a surgical procedure by failing to do either a retrograde ureteropyelogram, or by placing a left temporary stent post-surgery, and by failing to dictate his operative report until March 12, 2015. (See Exhibit H of the separate accompanying "Default Decision Evidence Packet", the Declaration of Robert Glaspie and attachments sealed in the evidence envelope).

b. On or about February 18, 2016, Investigator Glaspie was assigned to investigate Respondent regarding his care and treatment of Patients A and B. As part of his investigation, Investigator Glaspie sent medical records and Respondent's interview to Board expert Alan Weinberg, M.D., who then wrote his opinion that Respondent had committed with respect to Patients A and B. as follows:

1. Dr. Weinberg opined that Respondent committed four acts of gross negligence during his care and treatment of Patient A, by failing to document an informed consent discussion and/or have an informed consent discussion with Patient A prior to the surgical procedure (TVT pelvic surgery), as to options, risks and alternatives to surgery; by failing to document in the preoperative history and physical a detailed preoperative evaluation

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and/or workup of the alleged stress incontinence and what testing if any was done; by failing to have a complete and accurate operative report and legible and complete records for the follow-up visits post-surgery; and by failing to keep accurate and complete medical records for Patient A.

2. This expert further opined that Respondent committed repeated acts of negligence during his care and treatment of Patient A by failing to describe to Patient A, and/or document, the risk that mesh could pose in her October 1, 2015, TVT pelvic surgery, and respondent's failure to insure that the surgical packing was removed within 24 hours of the procedure from the patient's vaginal area.

3. Dr. Weinberg opined that Respondent committed four acts of gross negligence during his care and treatment of Patient B by failing to produce any office records for his treatment of Patient B, his failure to provide written notification to Patient B regarding termination of his care and/or his failure to assist Patient B in securing continuation of care with an appropriate medical provider. (See Exhibit H of the separate accompanying "Default Decision Evidence Packet", the Declaration of Robert Glaspie and attachments sealed in the evidence envelope).

c. Investigator Glaspie secured certified copies of the criminal complaint, plea and sentencing forms for two misdemeanor battery criminal convictions of respondent in case numbers PCM344707 and PCM339360. (See Exhibit H of the separate accompanying "Default Decision Evidence Packet", the Declaration of Robert Glaspie and attachments sealed in the evidence envelope).

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Richard Samuel Fightlin, M.D. has subjected his Physician's and Surgeon's Certificate No. G 20598 to discipline.

2. A copy of the Accusation, First Amended Accusation, Second Amended Accusation, and the related documents and Declaration of Service are attached.

3. The agency has jurisdiction to adjudicate this case by default.

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4. The Medical Board of California is authorized to revoke Respondent's Physician's and Surgeon's Certificate No. based upon the following violations alleged in the Accusation:

a. Bus. and Prof. Code section 2234, subdivision (b), where Respondent committed four acts of gross negligence during his care and treatment of Patient A, by failing to document an informed consent discussion and/or have an informed consent discussion with Patient A prior to the surgical procedure (TVT pelvic surgery), as to options, risks and alternatives to surgery; by failing to document in the preoperative history and physical a detailed preoperative evaluation and/or workup of the alleged stress incontinence and what testing, if any, was done; by failing to have a complete and accurate operative report and legible and complete records for the follow-up visits post-surgery; and by failing to keep accurate and complete medical records for Patient A.

b. Bus. and Prof. Code section 2234, subdivision (c), where Respondent committed repeated acts of negligence during his care and treatment of Patient A by failing to describe to Patient A, and/or document, the risk that mesh could pose in her October 1, 2015, TVT pelvic surgery, and respondent's failure to insure that the surgical packing was removed within 24 hours of the procedure from the patient's vaginal area.

c. Bus. and Prof. Code section 2266, where Respondent failed to keep accurate and complete records of his care and treatment of Patient A.

d. Bus. and Prof. Code section 2234, subdivision (b), where Respondent committed gross negligence during his care and treatment of Patient B, by failing to produce any office records for his treatment of Patient B, his failure to provide written notification to Patient B regarding termination of his care and/or his failure to assist Patient B in securing continuation of care with an appropriate medical provider.

e. Bus. and Prof. Code section 2266, where Respondent failed to keep accurate and complete records of his care and treatment of Patient B

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f. Bus. and Prof. Code section 2236, where Respondent suffered two misdemeanor convictions, one for a battery on his female office staff, committed in front of patients and for a battery on a patient's boyfriend after the boyfriend complained about respondent's verbal abuse toward the female patient that was his girlfriend.

g. Bus. and Prof. Code section 2234, subdivision (b), where Respondent committed gross negligence during his care and treatment of Patient D, by failing to evaluate and document the potential injury from this complicated operation of the ureteroscopy.

h. Bus. and Prof. Code section 2234, subdivision (b), where Respondent committed gross negligence during his care and treatment of Patient E, by failing to receive a complete informed consent from Patient E as well as his failure to perform adequate shockwave lithotripsey treatment.

i Bus. and Prof. Code section 2234, subdivision (b), where Respondent committed three acts of gross negligence during his care and treatment of Patient F, by making an incorrect pre-operative diagnosis, by Respondent regarding the presence of a right stent; by respondent making the wrong antibiotic choice for a pre-existent infection before surgery, as well as a lack of consideration of delaying surgery in light of the infection; and respondent's action of performing a forceful dilation of the right ureteral stricture using a semi rigid ureteroscope without a guide wire in combination with laser lithotripsy which caused ureteral injury.

j Bus. and Prof. Code section 2234, subdivision (b), where Respondent committed gross negligence during his care and treatment of Patient G, by Respondent opting to perform elective surgery, in a healthy, thirty-six week pregnant woman, rather than wait a few weeks until delivery of the patient's baby; Respondent failed to have a pre-operative urine test performed and documented before engaging in an invasive urological surgery; and Respondent showed a lack of concern regarding possible left ureteral injury to Patient G during a surgical procedure, by failing to do either a retrograde ureteropyelogram, or by placing a left temporary stent post-surgery, and by failing to dictate his operative report until March 12, 2015.

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ORDER

IT IS SO ORDERED that Physician's and Surgeon's Certificate No. G 20598, heretofore issued to Respondent Richard Samuel Fightlin, M.D., is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on April 25, 2018 at 5:00 p.m.

It is so ORDERED March 26, 2018

FOR THE MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

Kimberley Kirchmeyer
Executive Director

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
MARA FAUST
Deputy Attorney General
State Bar No. 111729
California Department of Justice
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7544
Facsimile: (916) 327-2247

Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against: **RICHARD SAMUEL FIGHTLIN, M.D.** 422 N Kanai Dr. Porterville, CA 93257-6911 Physician's and Surgeon's Certificate No. G 20598, Respondent.	Case No. 800-2015-018328 **SECOND AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Second Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about June 28, 1971, the Medical Board issued Physician's and Surgeon's Certificate No. G 20598 to Richard Samuel Fightlin, M.D. (Respondent). The Physician's and Surgeon's Certificate expired on April 30, 2017, and has not been renewed.

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JURISDICTION

3. This Second Amended Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

6. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

7. Section 2236 of the Code states in relevant part:

"(a) The conviction of any offense substantially related to the qualifications, functions, or duties of a physician and surgeon constitutes unprofessional conduct within the meaning of this chapter. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred."

"..."

"(d) A plea or verdict of guilty or a conviction after a plea of nolo contendere is deemed to be a conviction within the meaning of this section and section 2236.1. The record of conviction shall be conclusive evidence of the fact that the conviction occurred."

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence-Patient A)

8. Respondent Richard Samuel Fightlin, M.D., is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he committed gross negligence during the care and treatment of patient A[1]. The circumstances are as follows:

9. On or about September 29, 2015, Respondent undertook the care and treatment of patient A, a then 49-year-old female, who was complaining of urinary stress incontinence.

[1] Patient names will be provided in discovery.

Respondent's plan was to perform a transvaginal tape mid-urethral sling (TVT) procedure with cystoscopy. Though Respondent initially documented a history and physical in preparation for the surgical procedure, he did not include a documented informed consent discussion (including what options, risks, and alternatives to surgery existed), nor documented a detailed preoperative evaluation and what testing was done. There is no reference in the preoperative history and physical to preoperative workup of the alleged stress incontinence, no mention of options besides surgery, and no evaluation to characterize the type of incontinence in order to tailor the treatment options to the patient's clinical situation.

10. On or about October 1, 2015, Respondent performed the TVT procedure with cystoscopy on patient A. In his operative report, Respondent did not detail the placement or adjustment of the transvaginal tape, repair of the suprapubic punctures that were necessary, the blood loss, or instrument count. There are blank areas of the operative report that were not corrected and typographical errors that were not corrected. Post-surgery, Respondent documented four follow-up visits with patient A from approximately October 5 through 23, 2015, that are largely illegible and are incomplete, lacking documentation of history, examination or assessment.

11. During the October 1, 2015 pelvic surgery, Respondent used mesh in the procedure without documenting any discussion with patient A and/or having such discussion regarding the risk of the use of mesh, nor did Respondent provide any literature describing the risk that mesh can pose in the TVT procedure. In the post-surgical period, patient A continued to have pain and fever. In a follow-up visit on or about October 12, 2015, (post-surgery day eleven), it was discovered that the patient had a vaginal infection due to an approximately three-foot-long gauze packing that was left in her vaginal area. The vaginal packing from a TVT surgical procedure should be removed within 24 hours of the procedure.

12. Respondent's treatment of patient A as described above represents a separate and extreme departure from the standard of care in each of the following: (A) by failing to document an informed consent discussion and/or have an informed consent discussion with patient A prior to the surgical procedure as to options, risks and alternatives to surgery; (B) by failing to

document in the preoperative history and physical a detailed preoperative evaluation and/or workup of the alleged stress incontinence and what testing if any was done; (C) by failing to have a complete and accurate operative report and legible and complete records for the follow-up visits post-surgery; and (D) by failing to keep accurate and complete medical records for patient A.

SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts-Patient A)

13. Respondent Richard Samuel Fightlin, M.D., is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he was repeatedly negligent in his treatment of patient A. The circumstances are as follows:

14. Complainant re-alleges paragraphs 9 through 12.

15. Respondent's treatment of patient A as described above represents repeated negligent acts in that he failed to describe to patient A, and/or document, the risk that mesh could pose in her October 1, 2015, TVT pelvic surgery, and Respondent's failure to insure that the surgical packing was removed within 24 hours of the procedure from the patient's vaginal area.

THIRD CAUSE FOR DISCIPLINE
(Inaccurate and Incomplete Medical Records)

16. Respondent Richard Samuel Fightlin, M.D., is subject to disciplinary action under section 2266, of the Code, in that he failed to keep accurate and adequate medical records on patient A. The circumstances are as follows:

17. Complainant re-alleges paragraphs 9 through 12.

18. Respondent failed to keep accurate and complete records for patient A in the pre-surgical, surgical and post-surgical care.

FOURTH CAUSE FOR DISCIPLINE
(Gross Negligence-Patient B)

19. Respondent Richard Samuel Fightlin, M.D., is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he committed gross negligence during the care and treatment of patient B. The circumstances are as follows:

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20. On or about August 10, 2015, patient B, a then 41-year-old female, presented to the emergency room of Adventist Health Hospital in Hanford, California, with a complaint of left flank pain and blood in the urine. A CT scan showed left hydronephrosis (mass in the kidney) and phleboliths (calcium), but no kidney stones.

21. On or about August 11, 2015, Respondent, a urologist, performed a left retrograde pyelogram, a left ureteroscopy and a left double J stent placement. Before discharge, Patient B asked Respondent to fill out disability paperwork as she needed to take time away from her job.

22. Patient B had a follow-up office visit in Hanford with Respondent between August 18, 2015 and August 26, 2015. At that office visit, patient B complained about pain and occasional blood in her urine. Respondent indicated that her pain was not his problem and that he could refer her to someone else to treat her pain. When patient B asked about her disability paperwork that she gave Respondent in the hospital, he indicated that the paperwork was likely in his Porterville office and that he would bring it to her next appointment.

23. On or about September 1 or 2, 2015, patient B had a follow-up appointment with Respondent at his Hanford office. Patient B again complained about being in pain and Respondent replied that she should go to the hospital and find another doctor. When patient B asked where her disability paperwork was, Respondent started to use profanity with the patient stating that he wasn't a "explicative" secretary. Additionally, Respondent started to yell at his staff about the fact that patient B's chart was missing. Then Respondent yelled at patient B and said that he was done treating her as a patient. On or about September 2, 2015, Patient B then went directly to the Adventist Health Hospital and saw another urologist who diagnosed her with a UTI (urinary tract infection) and gave her medication that resolved her symptoms.

24. Respondent was unable to produce any office records for his treatment of patient B and such lack of records constitutes an extreme departure from the standard of care. In addition, Respondent's failure to provide written notification to patient B regarding termination of his care and/or his failure to assist patient B in securing continuation of care with an appropriate medical provider is an extreme departure from the standard of care.

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FIFTH CAUSE FOR DISCIPLINE
(Inaccurate and Incomplete Medical Records)

25. Respondent Richard Samuel Fightlin, M.D., is subject to disciplinary action under section 2266, of the Code, in that he failed to keep accurate and adequate medical records on patient B. The circumstances are as follows:

26. Complainant re-alleges paragraphs 19 through 24.

27. Respondent failed to keep accurate and complete records for patient B in regards to his post-surgical office care.

SIXTH CAUSE FOR DISCIPLINE
(Conviction of a Crime)

28. Respondent Richard Samuel Fightlin, M.D., is subject to disciplinary action under section 2236, of the Code, in that he suffered two criminal misdemeanor convictions that were substantially related to the practice of medicine. The circumstances are as follows:

29. On or about February 21, 2017, Respondent entered a plea of nolo contendere to a charge of Penal Code section 242 (battery), a misdemeanor, in Tulare County Superior Court Case No. PCM339360. Respondent was sentenced to three years of summary probation, thirty days jail and an anger management program.

30. The above referenced conviction in Case No. PCM339360 was based on the following underlying facts: On or about June 24, 2016, Respondent grabbed L.B., his office employee's arm hard and then hit L.B. in the back of her the head with his cell phone. Respondent was upset because another employee did not show up to work. A patient in the waiting room was recording the sounds of verbal and physical altercation between Respondent and L.B.

31. On or about February 21, 2017, Respondent entered a plea of nolo contendere to a charge of Penal Code section 242 (battery), a misdemeanor, in Tulare County Superior Court Case No. PCM344707. Respondent was sentenced to three years of summary probation, thirty days in jail and participation in an anger management program.

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32. The above referenced conviction in Case No PCM344707 was based on the following underlying facts: On or about May 30, 2016, Respondent was verbally abusive to patient C after her medical file was lost. Patient C went home upset about how Respondent had treated her. In response her boyfriend went to Respondent's office to speak to him. When patient C's boyfriend asked Respondent why he had been verbally abusive to patient C, Respondent stated that he would beat the "sh-t" out of him. Respondent attempted to hit patient C's boyfriend. Thereafter, Respondent stabbed patient C's boyfriend with an ink pen, causing breakage to the skin of the boyfriend's left forearm.

SEVENTH CAUSE FOR DISCIPLINE
(General Unprofessional Conduct)

33. Respondent Richard Samuel Fightlin, M.D., is subject to disciplinary action under section 2234, of the Code, in that he was unprofessional in his treatment of Patient C., her boyfriend, and his office manager. He is also subject to discipline for his unprofessional conduct with respect to patient C. The circumstances are as follows:

34. Complainant re-alleges paragraphs 28 through 32, and 21 through 23.

35. Respondent's conduct of hitting a staff person in the head in front of a patient on June 24, 2016, constitutes unprofessional conduct. Respondent's conduct of stabbing patient C's boyfriend with an ink pen causing a cut also constitutes unprofessional conduct. Respondent's use of profanity with patient B when she asked him about her disability paperwork also constitutes unprofessional conduct.

EIGHTH CAUSE FOR DISCIPLINE
(Gross Negligence-Patient D)

36. Respondent Richard Samuel Fightlin, M.D., is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he committed gross negligence during the care and treatment of patient D. The circumstances are as follows:

37. On or about November 7, 2013, Respondent undertook the care and treatment of patient D, a then 43-year-old male, when he placed ureteral stents in a patient with a history of bilateral stones. A kidney, ureter and bladder study, (KUB), showed a 13 mm stone in the

patient's left kidney, with thick calcification on the proximal end of the ureteral stent. Patient D consented to a cystoscopy, bilateral ureteroscopy, laser lithotripsy and stent removal. This surgery involving patient D, was performed by Respondent on December 29, 2014. According to the operative report, when Respondent was trying to remove the left stent, it broke and the proximal end of the stent was stuck over the sacral area. Left ureteroscopy with laser lithotripsy was done to break the stone on the stent and the stent was removed. However, a piece of the prosper jaw was broken and could not be found. A left stent was placed and the right stent removed. A CT scan done later did not show the broken piece of grasper and Respondent assumed that the patient had voided it out. Respondent's operative report does not describe whether a safety guide wire was used during the ureteroscopy nor whether there was any concern about possible ureteral injury. A retrograde ureteropyelogram would help determine any ureteral injury and Respondent did not document that this was considered or done.

38. Respondent's failure to evaluate and document the potential injury from this complicated operation constitutes an extreme departure from the standard of care.

NINTH CAUSE FOR DISCIPLINE
(Gross Negligence-Patient E)

39. Respondent Richard Samuel Fightlin, M.D., is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he committed gross negligence during the care and treatment of patient E. The circumstances are as follows:

40. On or about January 9, 2015, Respondent undertook the care and treatment of patient E, a female, when Respondent ordered an Extracorporeal Shock Wave Lithotripsy (ESWL), and placed a left urethral stent for treatment of a 28 mm left renal stone. The pre-operative informed consent documentation did not describe any discussion of alternative stone treatments such as percutaneous nephrostomy with lithotripsy. Additionally, there were insufficient shocks that resulted in this patient having to have later repeated surgery to deal with the same stone.

41. Respondent's failure to receive a complete informed consent from patient E as well as his failure to perform adequate shockwave lithotripsey treatment constitutes an extreme departure from the standard of care.

TENTH CAUSE FOR DISCIPLINE
(Gross Negligence-Patient F)

42. Respondent Richard Samuel Fightlin, M.D., is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he committed gross negligence during the care and treatment of patient F. The circumstances are as follows:

43. On or about January 15, 2015, Respondent undertook the care and treatment of patient F, a then 45-year-old female patient who had a prior unsuccessful attempt at right ureteral stent placement, a right nephrostomy tube placed and a left J stent placed on November 14, 2014. Respondent's planned surgery involved ureteroscopy/laser lithotripsy removal of the right and left stent, despite the fact that a right stent was not present in patient F. The antibiotic Ancef was ordered by Respondent for patient F without documentation of a urine culture result. Respondent stated in his operative report that there was a right ureteral stricture which was dilated with the ureteroscope and multiple stones were encountered in the proximal ureter. Further, the report stated that a laser was used to break the stones but large fragments were unable to be broken up or removed. Respondent's attempts to place a right ureteral stent was also unsuccessful. Later, patient F became sick and a post operative image showed that she had a perforated right ureter.

44. During his physician interview of June 6, 2017, Respondent stated that he was forced to dilate the stricture with ureteroscope because he was unable to pass a guide wire. Patient F had infected urine before surgery with Enterococcus that was not sensitive to Ancef.

45. Respondent's treatment of patient F as described above represents three separate extreme departures from the standard of care as follows: (A) an incorrect pre-operative diagnosis by Respondent regarding the presence of a right stent; (B) Respondent making the wrong antibiotic choice for a pre-existent infection before surgery, as well as a lack of consideration of delaying surgery in light of the infection; and (C) Respondent's action of performing a forceful dilation of the right ureteral stricture using a semi-rigid ureteroscope without a guide wire in combination with laser lithotripsy which caused ureteral injury.

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ELEVENTH CAUSE FOR DISCIPLINE
(Gross Negligence-Patient G)

46. Respondent Richard Samuel Fightlin, M.D., is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he committed gross negligence during the care and treatment of patient G. The circumstances are as follows:

47. On or about February 3, 2015, Respondent undertook the care and treatment of patient G, a then 25-year-old female patient, who was thirty-six weeks pregnant. Respondent performed a cystoscopy/left ureteroscopy and laser lithotripsy and stent removal of a stent previously placed on September 19, 2014. In the operative note from February 3, 2015, Respondent states that the left ureteral stent was heavily calcified and that he was unable to remove it. Respondent performed a ureteroscopy and laser to break the stones on the proximal end, followed by stent removal. Patient G was sent home after this procedure but was re-admitted to the hospital on February 5, 2015 in septic shock. A CT scan on February 6, 2015 showed that a ureteral stone of 6 mm was left from the surgical area and that there was a left ureteral perforation.

48. Respondent's treatment of patient G involves an extreme departure from the standard of care in that Respondent opted to perform elective surgery, in a healthy, thirty-six week pregnant woman, rather than wait a few weeks until delivery of the patient's baby; Respondent failed to have a pre-operative urine test performed and documented before engaging in an invasive urological surgery; and Respondent showed a lack of concern regarding possible left ureteral injury to patient G during a surgical procedure, by failing to do either a retrograde ureteropyelogram, or by placing a left temporary stent post-surgery, and by failing to dictate his operative report until March 12, 2015.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. G 20598, issued to Richard Samuel Fightlin, M.D.;

2. Revoking, suspending or denying approval of Richard Samuel Fightlin, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Richard Samuel Fightlin, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: February 5, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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